FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041889

Facility Name: CARE CENTRE OF CHAMPAIGN

Address: 1915 S. MATTIS AVE. (Number) CHAMPAIGN (City) 61821 (Zip Code)

County: CHAMPAIGN

Telephone Number: (847) 647 - 4700 **Fax #** (847) 674-4733

IDPA ID Number: 36-4082499

Date of Initial License for Current Owners: 06/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) BRADLEY ALTER
(Title) SECRETARY

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA/PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1
(Telephone) (847) 675-3585 Fax (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

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Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	118	Skilled (SNF)	118	43,188	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,188	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,087	2,087	8
9	SNF/PED					9
10	ICF	22,135	3,776	588	26,499	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,135	3,776	2,675	28,586	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 66.19%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 2087

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

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IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	120,696	5,640	4,531	130,867		130,867	0	130,867			1
2	Food Purchase		117,024		117,024		117,024	(6,075)	110,949			2
3	Housekeeping	73,556	18,241	0	91,797		91,797	304	92,101			3
4	Laundry	33,413	10,172	309	43,894		43,894	0	43,894			4
5	Heat and Other Utilities			65,160	65,160		65,160	239	65,399			5
6	Maintenance	27,828	13,529	7,981	49,338		49,338	1,209	50,547			6
7	Other (specify):*			3,403	3,403		3,403	0	3,403			7
8	**TOTAL General Services**	255,493	164,606	81,384	501,483		501,483	(4,323)	497,160			8
	B. Health Care and Programs											
9	Medical Director			7,800	7,800		7,800	0	7,800			9
10	Nursing and Medical Records	876,736	40,511	19,068	936,315		936,315	4,882	941,197			10
10a	Therapy	0	2,101	3,187	5,288		5,288	(8,480)	(3,192)			10a
11	Activities	32,854	1,554	1,121	35,529		35,529	0	35,529			11
12	Social Services	26,636		880	27,516		27,516	0	27,516			12
13	Nurse Aide Training			0				0				13
14	Program Transportation			0				0				14
15	Other (specify):*							0				15
16	**TOTAL Health Care and Progra**	936,226	44,166	32,056	1,012,448		1,012,448	(3,598)	1,008,850			16
	C. General Administration											
17	Administrative	76,801		40,500	117,301		117,301	(13,934)	103,367			17
18	Directors Fees			0				0				18
19	Professional Services			31,990	31,990		31,990	12,514	44,504			19
20	Dues, Fees, Subscriptions & Promotions			21,042	21,042		21,042	(7,559)	13,483			20
21	Clerical & General Office Expense	33,673	10,938	80,779	125,390		125,390	(22,005)	103,385			21
22	Employee Benefits & Payroll Taxes			178,780	178,780		178,780	0	178,780			22
23	Inservice Training & Education			1,927	1,927		1,927	0	1,927			23
24	Travel and Seminar			0				5,372	5,372			24
25	Other Admin. Staff Transportation			3,082	3,082		3,082	3,042	6,124			25
26	Insurance-Prop.Liab.Malpractice			30,233	30,233		30,233	1,570	31,803			26
27	Other (specify):*			0				27,871	27,871			27
28	**TOTAL General Administration**	110,474	10,938	388,333	509,745		509,745	6,871	516,616			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,302,193	219,710	501,773	2,023,676		2,023,676	(1,050)	2,022,626			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			25,590	25,590		25,590	(10,352)	15,238			30
31	Amortization of Pre-Op. & Org.			1,140	1,140		1,140	0	1,140			31
32	Interest			118,593	118,593		118,593	(2,182)	116,411			32
33	Real Estate Taxes			36,110	36,110		36,110	0	36,110			33
34	Rent-Facility & Grounds			394,390	394,390		394,390	3,670	398,060			34
35	Rent-Equipment & Vehicles			15,919	15,919		15,919	3,683	19,602			35
36	Other (specify):*							0				36
37	TOTAL Ownership			591,742	591,742		591,742	(5,181)	586,561			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		41,819	76,885	118,704		118,704	0	118,704			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			64,782	64,782		64,782	0	64,782			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		41,819	141,667	183,486		183,486		183,486			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,302,193	261,529	1,235,182	2,798,904	0	2,798,904	(6,231)	2,792,673			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Previe

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(12,532)	30		9
10	Interest and Other Investment Income	(2,544)	32		10
11	Discounts, Allowances, Rebates & Refunds	(5,338)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(737)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties		21		18
19	Entertainment	0	20		19
20	Contributions	0	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(9,600)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	(472)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	1,129	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (30,094)		$	30

OHF USE ONLY								
48		49		50		51	52	

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	23,863	SCHED	34
35	Other- Attach Schedule	0	TTACHED	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 23,863		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (6,231)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Previe

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.
The amounts in columns F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

STATE OF ILLINOIS **Page 5A**

Facility Name CARE CENTRE OF CHAMPAIGN
ID# 0041089
Report Period Beginning: 01/01/2009
Ending: 12/31/2009

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V Line	Adj. Summary
The information listed in B13 thru G43 is from Page 5.					
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	(6,972)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	0	2	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 5**	0
6	**Rented Facility Space**	0	34	**Line 6**	1,128
7	**Sale of Supplies to Non-Patients**	0	10	**Line 7**	0
8	**Laundry for Non-Patients**	0	4	**Line 8**	(4,500)
9	**Non-Straightline Depreciation**	(12,532)	30	**Line 9**	0
10	**Interest and Other Investment Income**	(2,544)	32	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	(5,338)	2	**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	0
13	**Sales Tax**	(737)	2	**Line 12**	0
14	**Non-Care Related Interest**	0	32	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	25	**Line 15**	0
17	**Non-Care Related Fees**	0	20	**Line 16**	0
18	**Fines and Penalties**	0	21	**Line 17**	0
19	**Entertainment**	0	20	**Line 18**	0
20	**Contributions**	0	20	**Line 19**	0
21	**Owner or Key-Man Insurance**	0	22	**Line 20**	(10,872)
22	**Special Legal Fees & Legal Retainers**	0	19	**Line 21**	0
23	**Malpractice Insurance for Individuals**	0	26	**Line 22**	0
24	**Bad Debt**	0	27	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(9,608)	20	**Line 24**	0
26	**Income & IL Personal Property Replacement T**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	13	**Line 26**	0
28	**Yellow Page Advertising**	(472)	20	**Line 27**	0
29	**Non-Paid Workers**	0	0	**Line 28**	(10,872)
30	**Donated Goods**	0	0	**Line 29**	(15,844)
31	**Amortization Expense**	0	0	**Line 30**	(12,532)
32	DEFERRED MAINTENANCE	1,329	6	**Line 31**	0
				Line 32	(2,544)
				Line 33	0
				Line 34	0
				Line 35	0
				Line 36	0
				Line 37	(15,076)
				Line 38	0
				Line 39	0
				Line 40	0
				Line 41	0
				Line 42	0
				Line 43	0
				Line 44	0
				Line 45	(30,899)

Print Other Adjustments

Reference 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Numb CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,075)	0	0	0	0	0	0	0	0	0	0	(6,075)	2
3	Housekeeping	0	0	304	0	0	0	0	0	0	0	0	304	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	239	0	0	0	0	0	0	0	0	239	5
6	Maintenance	1,129	0	80	0	0	0	0	0	0	0	0	1,209	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,946)	0	623	0	0	0	0	0	0	0	0	(4,323)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	4,882	0	0	0	0	0	0	0	0	4,882	10
10a	Therapy	0	(50,160)	0	41,680	0	0	0	0	0	0	0	(8,480)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	(50,160)	4,882	41,680	0	0	0	0	0	0	0	(3,598)	16
	C. General Administration													
17	Administrative	0	(40,500)	26,566	0	0	0	0	0	0	0	0	(13,934)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	12,133	381	0	0	0	0	0	0	0	12,514	19
20	Fees, Subscriptions & Promotions	(10,072)	0	2,513	0	0	0	0	0	0	0	0	(7,559)	20
21	Clerical & General Office Expenses	0	(64,580)	42,441	134	0	0	0	0	0	0	0	(22,005)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	4,772	600	0	0	0	0	0	0	0	5,372	24
25	Other Admin. Staff Transportation	0	0	1,768	1,274	0	0	0	0	0	0	0	3,042	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,570	0	0	0	0	0	0	0	0	1,570	26
27	Other (specify):*	0	0	22,685	5,186	0	0	0	0	0	0	0	27,871	27
28	**TOTAL General Administration**	(10,072)	(105,080)	114,448	7,575	0	0	0	0	0	0	0	6,871	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(15,018)	(155,240)	119,953	49,255	0	0	0	0	0	0	0	(1,050)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(12,532)	0	2,180	0	0	0	0	0	0	0	0	(10,352)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,544)	0	362	0	0	0	0	0	0	0	0	(2,182)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	3,670	0	0	0	0	0	0	0	0	3,670	34
35	Rent-Equipment & Vehicles	0	0	2,643	1,040	0	0	0	0	0	0	0	3,683	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(15,076)	0	8,855	1,040	0	0	0	0	0	0	0	(5,181)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Cent**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(30,094)	(155,240)	128,808	50,295	0	0	0	0	0	0	0	(6,231)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe CARE CENTRE OF CHAMPAIG7 # 0041089 Report Period Beginning 01/01/2000 Ending 12/31/2000

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		CERTIFIED HEAL	SKOKIE	BOOKKEEPING
				MANAGEMENT, INC.		MANAGEMENT
				CHM THERAPY	SKOKIE	THERAPY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
1	V	17 MANAGEMENT FEES	$ 40,500	CERTIFIED HEALTH MANAGEMEN	0	0	(40,500)	1	-40500
2	V	21 BOOKKEEPING FEES	64,580	CERTIFIED HEALTH MANAGEMEN			(64,580)	2	-64580
3	V							3	
4	V							4	
5	V							5	
6	V	10a THERAPY	50,160	CHM THERAPY			(50,160)	6	-50160
7	V							7	
8	V							8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		$ 155,240		0	0 *	(155,240)	14	

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

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SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	3	HOUSEKEEPING	$	CERTIFIED HEALTH MANAGEMENT		$ 304	$ 304	15	304
16	V	5	ELECTRICITY & GAS		" " "		239	239	16	239
17	V	6	MAINTENANCE		" " "		80	80	17	80
18	V	10	NURSING & MEDICAL RECORDS		" " "		4,882	4,882	18	4882
19	V	17	ADMIN SALARIES		" " "		26,566	26,566	19	26566
20	V	19	PROFESSIONAL FEES		" " "		12,133	12,133	20	12133
21	V	20	FEES, SUBSCRIPTION		" " "		2,513	2,513	21	2513
22	V	21	OFFICE EXPENSE		" " "		42,441	42,441	22	42441
23	V	27	EMPLOYEE BENEFITS		" " "		22,685	22,685	23	22685
24	V	24	TRAVEL & SEMINAR		" " "		4,772	4,772	24	4772
25	V	25	TRANSPORTATION		" " "		1,768	1,768	25	1768
26	V	26	INSURANCE		" " "		1,570	1,570	26	1570
27	V	30	DEPRECIATION		" " "		2,180	2,180	27	2180
28	V	32	INTEREST		" " "		362	362	28	362
29	V	34	OFFICE RENT		" " "		3,670	3,670	29	3670
30	V	35	EQUIPMENT RENT		" " "		2,643	2,643	30	2643
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 128,808	$ * 128,808	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		Sum_6B
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	10a	THERAPY	$	CHM THERAPY		$ 41,680	$ 41,680	15	41680
16	V	19	PROFESSIONAL FEE		" "		381	381	16	381
17	V	21	OFFICE EXPENSE		" "		134	134	17	134
18	V	27	EMPLOYEE BENEFITS		" "		5,186	5,186	18	5186
19	V	24	TRAVEL & SEMINARS		" "		600	600	19	600
20	V	25	TRANSPORTATION		" "		1,274	1,274	20	1274
21	V	35	EQUIPMENT RENT		" "		1,040	1,040	21	1040
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 50,295	$ * 50,295	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6C

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

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SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	BRADLEY ALTER		ADMINISTRATIVE		SCHEDULE ATTACHED			SALARY	$ 16,957	17-7	1
2	HOWARD GELLER		ADMINISTRATIVE					MGMT FEE	8,775	19-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 25,732		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

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the name(s)
PORTS.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8 | Show Pgs 8E thru 8 | Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CERTIFIED HEALTH MANAGEMENT
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-4700
Fax Number: (847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PATIENT DAYS	282,193	8	$ 3,000	$	28,586	$ 304	1
2	5	ELECTRICITY & GAS	" "	282,193	8	2,363		28,586	239	2
3	6	MAINTENANCE	" "	282,193	8	794		28,586	80	3
4	10	NURSING & MEDICAL REC	" "	282,193	8	48,193	48,193	28,586	4,882	4
5	17	ADMIN SALARIES	" "	282,193	8	262,258	262,258	28,586	26,566	5
6	19	PROFESSIONAL FEES	" "	282,193	8	103,352		28,586	12,133	6
7	20	FEES, SUBSCRIPTION	" "	282,193	8	24,805		28,586	2,513	7
8	21	OFFICE EXPENSE	" "	282,193	8	418,964	287,637	28,586	42,441	8
9	27	EMPLOYEE BENEFITS	" "	282,193	8	223,938		28,586	22,685	9
10	24	TRAVEL & SEMINAR	" "	282,193	8	47,103		28,586	4,772	10
11	25	TRANSPORTATION	" "	282,193	8	17,449		28,586	1,768	11
12	26	INSURANCE	" "	282,193	8	15,497		28,586	1,570	12
13	30	DEPRECIATION	" "	282,193	8	21,518		28,586	2,180	13
14	32	INTEREST	" "	282,193	8	3,570		28,586	362	14
15	34	OFFICE RENT	" "	282,193	8	36,234		28,586	3,670	15
16	35	EQUIPMENT RENT	" "	282,193	8	26,088		28,586	2,643	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,255,126	$ 598,088		$ 128,808	25

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STATE OF ILLINOIS

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: CHM THERAPY
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-4700
Fax Number: (847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10a	THERAPY	USAGE	100	5	$ 237,623	$ 237,623	18	$ 41,680	1
2	19	PROFESSIONAL FEE	USAGE	100	5	2,171		18	381	2
3	21	OFFICE EXPENSE	USAGE	100	5	762		18	134	3
4	27	EMPLOYEE BENEFITS	USAGE	100	5	29,544		18	5,186	4
5	24	TRAVEL & SEMINARS	USAGE	100	5	3,419		18	600	5
6	25	TRANSPORTATION	USAGE	100	5	7,260		18	1,274	6
7	35	EQUIPMENT RENT	USAGE	100	5	5,926		18	1,040	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 286,705	$ 237,623		$ 50,295	25

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Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Previe

Print Page 8

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Previe

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Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Previe

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	OLD KENT BANK		X	WORKING CAPITAL				400,000			34,147	6
7	SHAREHOLDERS	X		WORKING CAPITAL				879,000			84,446	7
8	RELATED PARTY	X									362	8
9	TOTAL Facility Related						$	$ 1,279,000			$ 118,955	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 1,279,000			$ 118,955	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Previe

Facility Name & ID Numbe CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	37,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	36,193	2
3. Under or (over) accrual (line 2 minus line 1).	$	(807)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	36,917	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	36,110	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997	36,013	10
1998	36,251	11
1999	36,193	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Previe

Facility Name & ID Numb CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,000 B. General Construction Type: Exterior CONCRETE Frame STEEL CONSTR Number of Stories

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 5,664 2. Number of Years Over Which it is Being Amortized: 5 YEARS

3. Current Period Amortization: 1,140 4. Dates Incurred: 6/96

Nature of Costs: ORGANIZATION COSTS

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8						245		245			8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	ROOFING			1996	9,253	237	39	237		1,037	9
10	SIDEWALK & PATIO			1996	4,146	277	15	277		1,177	10
11	DOOR INSTALLED			1996	636	16	39	16		66	11
12	HANDRAIL & BUMPER GUARD			1997	2,620	67	39	67		209	12
13	FLOOR TILES & CARPETS			1997	19,732	506	39	506		1,539	13
14	FLOORING, WALLPAPER, CEILING REPAIR			1998	13,669	351	39	351		995	14
15	ELECTRICAL WORK			1998	7,500	192	39	192		504	15
16	LANDSCAPING			1998	11,551	770	15	770		1,925	16
17	DRYWALL & CEILING REPAIR			1999	3,860	99	39	99		186	17
18	ROOF REPAIR			1999	3,109	80	39	80		137	18
19	SIDEWALK REPAIR			1999	4,023	268	15	268		402	19
20	ROOF REPAIR			2000	10,000	288	27.5	288		288	20
21	WALLPAPER			2000	2,440	349	20	122	(227)	122	21
22	WALL/CEILING REPAIR			2000	1,425	32	27.5	32		32	22
23	CURCUIT BREAKERS			2000	710	1	27.5	1		1	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 3,778		$ 3,551	$ (227)	$ 8,620	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 91,288	$ 18,748	$ 9,129	$ (9,619)	10 YRS	$ 22,335	37
38	Current Year Purchases	20,287	3,309	1,014	(2,295)	10 YRS	1,014	38
39	Fully Depreciated Assets							39
40	RELATED PARTY	15,443	1,935	1,544	(391)			40
41	TOTALS	$ 127,018	$ 23,992	$ 11,687	$ (12,305)		$ 23,349	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 27,770	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 15,238	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (12,532)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 31,969	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: CARE CENTER OF CHAMPAIGN
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		118	06/01/96	$ 394,390	25		3
4	Additions							4
5								5
6								6
7	TOTAL		118		$ 394,390 **			7

10. Effective dates of current rental agreement:
    Beginning 06/01/96
    Ending 05/31/21

11. Rent to be paid in future years under the curre rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2001	$ 411,005
13.	12/31/2002	$ 425,871
14.	12/31/2003	$ 436,365

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: AFTER 06/01/16 *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipm $ 15,919 Description: SEE SCHEDULE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Cost	Outside Practitioner (other than consultant) Units	Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs		$		$ 40,292	$		$ 40,292	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				198			198	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				33,906			33,906	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts					24,746		24,746	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): RENTAL / LAB						2,489	17,073		19,562	13
14	TOTAL				$		$ 76,885	$ 41,819		$ 118,704	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 118,000)	426,860		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	66,741		6
7	Other Prepaid Expenses	1,255		7
8	Accounts Receivable (owners or related parties)	326,624		8
9	Other(specify): RE ESCROW	33,222		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 854,702	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	94,674		15
16	Equipment, at Historical Cost	111,575		16
17	Accumulated Depreciation (book methods)	(58,140)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	5,664		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(5,225)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS	345,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 493,548	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,348,250	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 225,569	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	471,167		29
30	Accrued Salaries Payable	32,320		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,210		31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,917		32
33	Accrued Interest Payable	63,789		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DEFERRED INCOME	55,490		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 888,462	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	879,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 879,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,767,462	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (419,212)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,348,250	$	48

***(See instructions.)**

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Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (630,753)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (630,753)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	211,541	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 211,541	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (419,212)	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,932,781	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,932,781	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	69,055	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 69,055	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,544	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 2,544	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**DISCOUNTS**	5,338	28
28a	**VENDING COMMISSION**	727	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,065	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 3,010,445	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 501,483	31
32	Health Care	1,012,448	32
33	General Administration	509,745	33
	B. Capital Expense		
34	Ownership	591,742	34
	C. Ancillary Expense		
35	Special Cost Centers	118,704	35
36	Provider Participation Fee	64,782	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,798,904	40
41	**Income before Income Taxes (line 30 minus line 40)****	211,541	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ 211,541	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,960	2,080	$ 39,785	$ 19.13	1
2	Assistant Director of Nursing	2,028	2,047	38,511	18.81	2
3	Registered Nurses	5,581	5,693	98,117	17.23	3
4	Licensed Practical Nurses	9,430	9,662	148,799	15.40	4
5	Nurse Aides & Orderlies	50,407	50,588	497,245	9.83	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,562	1,602	12,560	7.84	9
10	Activity Assistants	1,458	1,642	20,294	12.36	10
11	Social Service Workers	3,212	3,356	26,636	7.94	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	29,911	14.38	13
14	Head Cook	5,182	5,296	42,648	8.05	14
15	Cook Helpers/Assistants	7,133	7,153	48,137	6.73	15
16	Dishwashers					16
17	Maintenance Workers	1,981	2,109	27,828	13.19	17
18	Housekeepers	11,022	11,298	73,556	6.51	18
19	Laundry	4,973	4,983	33,413	6.71	19
20	Administrator	1,960	2,080	48,464	23.30	20
21	Assistant Administrator	1,960	2,080	28,337	13.62	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,212	2,380	33,673	14.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,984	2,040	19,533	9.58	31
32	Other Health Care(specify)					32
33	Other(specify CARE PLAN	1,960	2,080	34,746	16.70	33
34	TOTAL (lines 1 - 33)	117,965	120,249	$ 1,302,193 *	$ 10.83	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 4,307	1-3	35
36	Medical Director	O	7,800	9-3	36
37	Medical Records Consultant	N	3,073	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	825	10-3	39
40	Physical Therapy Consultant	L	235	10a-3	40
41	Occupational Therapy Consulta	Y	0	10a-3	41
42	Respiratory Therapy Consultant		700	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,121	11-3	44
45	Social Service Consultant	E	880	12-3	45
46	Other(specify)	S			46
47			0		47
48					48
49	TOTAL (lines 35 - 48)		$ 18,941		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JUDY WEGER	ADMIN	0.00%	$ 48,464
	ASST ADMIN	0.00%	28,337
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,801

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 40,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 40,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SCHEDULE ATTACHED		$ 31,990
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 31,990

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 25,035
Unemployment Compensation Insurance	26,107
FICA Taxes	99,622
Employee Health Insurance	25,571
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	2,131
EMPLOYEE BENEFITS-OTHER	314
EMPLOYEE PHYSICAL EXAMS	0
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 178,780

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,537
Health Care Worker Background Chec	0
(Indicate # of checks performed)	
ADV & PROMO/MARKETING	10,072
DUES & SUBSCRIPTIONS	6,027
LICENSES & PERMITS	406
TRUST FEES, CONTRIBUTIONS,etc.	0
MGMT CO ALLOCATION	2,513
LESS TRUST FEES, CONTRIB, etc.	0
Less: Public Relations Expense	( )
Non-allowable advertising	(9,600)
Yellow page advertising	(472)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,483

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	0
RELATED PARTY	5,372
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,372

* Attach copy of IMRF notifications

**See instructions.

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